city**benefits** new**directions**

Summary 2005

CITY OF LONG BEACH

to city of long beach **employees**

Welcome to Open Enrollment 2005. The City is once again pleased to offer you a variety of quality health care plans to meet your needs. This year, we are introducing **New Directions** for your City benefits. Due to continuing double-digit increases in the cost of our plans, **New Directions** brings significant plan changes. The payroll deductions will be higher on many plan combinations. Yet even with this change, the City's health plan benefits remain extremely competitive when compared with those offered by similar employers.

The bottom line is that health care costs continue to rise at alarming rates. Our overall costs for health benefits, driven by hospital (inpatient and outpatient) and pharmacy expenses, continue to increase dramatically. Our plan design changes are one way to help mitigate these rising costs without reducing the quality and value of the plans you have come to count on as City employees. In addition, you are encouraged to do your part by using your benefits wisely. Page 9 of this Summary Booklet suggests ways that you can help keep health care costs under control.

It is critical this year for you to review your printed materials before making decisions about your benefits. Highlights of the plan changes are listed below, but these highlights do not include all of the important details, such as new deductible and copayment amounts. Read this Summary Booklet and refer to the comparison grid on pages 10-13 for additional information.

Changes for 2005

- The Long Beach Choice POS / Great-West POS Plans are being replaced by the revised POS 100 Plan, or POS 90 Plan, depending on the plan you choose. Both new plans are the same except for the percentages paid. The POS 100 Plan pays 100% of covered in-network expenses after deductible, while the POS 90 Plan pays 90% of covered in-network expenses after deductible. Covered out-of-network expenses for both plans are paid at 50% after deductible. Refer to the benefits comparison grid for more information.
- The High, Value and Low PPO Plans are being replaced by a single PPO Plan that pays 80% of most in-network services after the deductible, and 60% of most out-of-network services after the deductible.
- A High Deductible PPO Plan is being added for those who are willing to pay higher deductibles ($1,000 per person / $2,000 per family) before receiving plan benefits. This plan pays 90% of most in-network services up to specified limits (after deductible), and 60% of most out-of-network services up to specified limits (after deductible).
- A three-tier prescription drug plan with formulary, administered by EXPRESS SCRIPTS, will replace the existing prescription drug program for the POS 100 Plan, POS 90 Plan, and PPO Plan. The copays will be $10 for Generic drugs; $25 for Brand Preferred; and the higher of $40 or 30% for Brand Non-Preferred. Mail Order services are available at two times the applicable copay for a 90-day supply.

Prepare for Enrollment

Due to this year's plan changes, you must complete an enrollment form even if you do not change plans.

Please take the time to read this booklet thoroughly and make your selections carefully. The choices you make during this open enrollment will be effective from December 1, 2004 through November 30, 2005. If you have access to a computer, you may want to visit your plan's website for up-to-date provider information, wellness tips and helpful advice on how to make the most of your coverage. You can also print a copy of the plan's drug formulary.

For Great West Healthcare members, the website address is **www.mygreatwest.com**. PacifiCare members should log on to **www.pacificare.com**.

You and your family are also encouraged to attend one of the Question and Answer sessions offered during open enrollment. The dates, times and locations are listed at the back of this Summary Booklet. If you need more information, refer to the contact information on the back cover, or visit our web site at http://wmirror. (Click on "HR Employee Page.")

Have a safe and healthy year.

Sincerely,

Deborah R Mills

DEBORAH R. MILLS
Employee Benefits & Services Officer

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This Benefits Summary reviews health, dental and life insurance benefits for the City of Long Beach, but it is not a contract. Full details about the benefits are provided in legal plan documents and insurance contracts that govern the program. If there are differences between this Benefits Summary and those documents and contracts, the legal documents will control.

The actual plan documents may be inspected upon written request to the Employee Benefits & Services Officer at least 10 days prior to review. A copy of the entire plan document(s) may be obtained in the same manner for a 25-cent per page copying charge.

citybenefits newdirections

The 2005 Plan Year brings **New Directions** for your City of Long Beach benefits program. Many plan changes have been made to help control rising health care costs and still keep employee contributions for coverage at a reasonable level. The good news is that, even with the changes, the City's benefits program remains competitive compared with the programs offered by similar employers, and continues to offer important choices to meet your needs.

REVIEW YOUR BENEFIT MATERIALS

Take some time to review the benefit materials before making your choices. You'll soon discover it's well worth the effort!

Before choosing your coverage, read all of your printed materials, analyze your personal situation and decide what combination of benefits will work for you. This Benefits Summary is designed to make this process as easy as possible. The table below shows a list of the benefit plans available. Please note that there are no changes to the life insurance, dental and vision plans.

A Place to Start

Medical coverage is perhaps the most important of your benefits. Not only does it help you maintain wellness, but it protects against major financial strain should you or a family member need extensive medical care. To help you select the best plan for you, consider these questions:

- How much have you used medical coverage in the past, and what types of services do you use?
- How much financial risk are you comfortable with?
- Do you like the concept of receiving all of your care from providers who belong to a network? Or do you want the freedom to visit other providers, even if you pay more?
- Would you like to choose your own physician when you receive treatment?

TYPE OF COVERAGE	OPTIONS	WHO CAN BE COVERED
Medical	• POS 100 Plan • POS 90 Plan • PPO Plan • High Deductible PPO Plan • PacifiCare HMO Plan	You and your eligible dependents
Dental	• Delta Dental Plan • PacifiCare Dental Plan	You and your eligible dependents
Life Insurance	• $20,000 of insurance	You
In-Hospital Insurance	• In-Hospital Indemnity Plan, which pays additional benefits for hospitalization	You and your eligible dependents
Professional Counseling Services	• Employee Assistance Program (EAP)	You and your eligible dependents
Long Term Care	• Long Term Care Plan which provides financial help for care needed at home or in a nursing home when you cannot care for yourself	You and your eligible dependents

eligibility

Following are the eligibility rules for the City's group insurance plans:

1. Employees must be permanent, full-time City employees. *Permanent* — A position in which the duties of the position are not expected to terminate at any given time. *Full-Time* — A position which normally requires an employee to work a forty-hour work week.
2. New employees hired on the first through fourth of the month are eligible on the first of the following month (i.e. hired July 1, eligible August 1).
3. New employees hired on or following the fifth of the month are eligible on the first of the month following or coinciding with one full month of employment (i.e. hired July 5, eligible September 1).

Upper Age Limit for Eligible Children

- The age limit for unmarried dependent children is age 19.
- The upper age limit for unmarried full-time students (dependent on their parents for at least half of their economic support) is through age 25. To maintain coverage for a student, a copy of the student's registration must be mailed or faxed to the insurance carrier each semester/quarter. When a student reaches age 26, coverage will terminate unless the student elects to enroll in COBRA.
- Unmarried children age 19 or over who are physically or mentally incapable of self-support may be continued under the health and dental care plans while remaining incapacitated, provided you continue your own coverage. To continue a child under this provision, the child must have been covered under the plan on the day before he or she would otherwise lose dependent status. Proof of incapacity must be provided within 30 days of the date the child would lose coverage (such as 30 days prior to turning age 19, losing full-time student status or turning age 26).

Adding New Dependents

Employees *must* complete the form to add new dependents within 30 days of becoming eligible. The effective date of coverage for new dependents may vary with each plan. A form to add new dependents and information regarding effective dates of coverage can be obtained from your Departmental Payroll/Personnel Assistant.

NOTE: If an employee does not complete the form to add the new dependent(s) within the required 30 days, the employee will not be able to add that dependent(s) until the next open enrollment period.

Eligible Dependents Include

- Legal spouse (a divorced spouse is not eligible)
- Unmarried natural children
- Unmarried step-children
- Domestic partners (same sex only)
- Disabled unmarried adult children
- Unmarried legally adopted children
- Unmarried foster children covered under legal custody.

NOTE: Mothers, fathers, grandparents, aunts, uncles, brothers, sisters, grandchildren, nephews, nieces, cousins, etc. are not eligible dependents. Legal custody for anyone other than a foster child(ren) does not make that person an eligible dependent.

Also, a divorced spouse is not eligible for continued coverage as a dependent under the employee's benefits program, even if the court orders the subscriber to provide coverage. Please refer to the COBRA rules (page 19) for information on coverage after a divorce.

Verification for Dependent Spouse

- Marriage license or certificate.

Verification for Domestic Partners

- *Certain qualification rules apply for domestic same sex partner coverage. Contact Human Resources for details.*

Verification for Dependent Children (one or more of the following)

- Birth or baptismal certificate
- Physician statement for disabled children
- Court orders for adoption
- Court orders for legal custody of foster children placed in a Certified Foster Home
- Final decree of divorce (requires only that portion which lists the names of dependents).

Please note that marriage certificates and birth certificates must have the state or county Certified Seal of where the event took place.

A certified marriage or birth certificate is issued by the State, County, or City Vital Statistics Office in accordance with federal guidelines. The document also has a traceable number. Birth certificates issued by hospitals are not official birth records and will not be accepted as proof of birth. Marriage certificates issued by a church or wedding chapel are not official marriage records and are not acceptable.

Official birth certificates can be obtained from the Long Beach Department of Health and Human Services for new babies born in the City of Long Beach.

Verification for Dependent Full-Time Student

- Any of the above verifying documents for dependent children and an appropriate federal tax return (requires only that portion which lists the names of the dependents). In addition, a copy of the student's registration must be mailed or faxed to the insurance carrier each semester/quarter.

PacifiCare of California
Attn: Student Status
5701 Katella Ave.
Cypress, CA 90630
Mail Stop CY24-515
Fax: (714) 226-5766

Great-West Healthcare
PO Box 11111
Fort Scott, KS 66701
Fax: (818) 247-3597

IF YOU WISH TO WAIVE COVERAGE

If you wish to waive your health, dental and life benefits, you must complete a new "Waiver" form each year you do not want coverage.

City of Long Beach In-Hospital Indemnity Eligibility

Please obtain a plan brochure from your Departmental Payroll/Personnel Assistant.

Loss of Eligibility

An employee and/or his or her dependent(s) will lose the right of coverage when he or she is not in compliance with the eligibility rules. Thus, an individual is not covered as a result of termination, reduction in hours (less than full-time status), divorce, etc. It is the employee's responsibility to inform his or her Departmental Payroll / Personnel Assistant within 30 days of any event which would result in a status change. You must complete and return an enrollment form to delete dependents no longer eligible.

Continuation of benefits may be available through COBRA benefit provisions when health benefits would ordinarily terminate. In these cases, as well as in the event of a leave of absence or total disability, continuation of benefits may be available by self-paying the premiums (see page 19).

For more information regarding eligibility, loss of eligibility, or COBRA benefits, please see your Departmental Payroll/Personnel Assistant.

enrollment

Open Enrollment

Open enrollment runs from September 27, through October 8. You may enroll any time during this period. The benefits you elect will be effective for one year — from December 1, 2004, to November 30, 2005. If you don't return completed forms by October 8 at 4:30 p.m.:

- You will receive the PPO medical plan for yourself and covered dependents, and your current dental plan (with covered dependents) and life insurance (with beneficiaries) will automatically apply for the coming plan year. PacifiCare members will be re-enrolled in PacifiCare.

Your Departmental Payroll/Personnel Assistant will provide you with a preprinted form that shows your current medical and dental plan choices. If you wish to:

- change your health plan;
- change your dental plan;
- add an eligible dependent(s);
- delete a dependent(s); or
- change your address

please make your changes on this form.

Enrollment for New Employees

If you're hired on days 1-4 of the month, you become eligible for coverage on the first of the following month. If you're hired on or after day 5 of the month, eligibility for coverage starts on the first of the month following one full month of employment. You must complete an enrollment form and return it within 30 days of your hire date. If you don't return your completed form by this deadline, you'll be automatically enrolled for:

- Coverage under the PPO Plan
- Coverage under the Delta Dental Plan
- Life insurance on yourself

Your benefits will be effective until the next open enrollment period.

Changes for 2005

For 2005, employee contributions for benefits may, depending on your health plan choice, be higher than they were in the past. However, the City continues to pay the greater share of the cost to provide your coverage. Here is an overview of other important changes for 2005:

- The Long Beach Choice POS Plan is being replaced by the "POS 100 Plan," which pays 100% for most in-network services after an individual deductible of $100 ($200 per family); and 50% of most out-of-network services after an individual deductible of $300, or $600 per family. Some services require a $20 copayment.
- A new "POS 90 Plan" pays 90% for most in-network services after an individual deductible of $100 ($200 per family); and 50% for most out-of-network services after an individual deductible of $300, or $600 per family. Some services require a $20 copayment.
- The High, Value and Low PPO Plans have been replaced by a single PPO Plan. After an individual deductible of $300 ($600 per family), this plan pays 80% of most covered services in-network. Non-network services are covered at 60% after a deductible of $500 per person, or $1,000 per family. Some services require a $25 copayment.
- A High Deductible PPO Plan is being added for those who are willing to pay higher deductibles ($1,000 per person / $2,000 per family) before receiving plan benefits. This plan pays 90% of most in-network services up to specified limits (after deductible), and 60% of most out-of-network services up to specified limits (after deductible).
- A three-tier prescription drug plan with formulary, administered by EXPRESS SCRIPTS, will replace the existing prescription drug program for the POS 100 Plan, POS 90 Plan, and PPO Plan. The copays will be $10 for Generic drugs; $25 for Brand Preferred; and the higher of $40 or 30% for Brand Non-Preferred. Mail Order services are available at two times the applicable copay for a 90-day supply.

costs for coverage

The City of Long Beach pays most or, in some cases, all of the cost for your medical and dental coverage, as well as life insurance. The amount you pay, if any, is based on the plans you choose and your coverage status (Employee Only; Employee + One Dependent; or Employee + Family). Refer to the Cost Insert included with your enrollment materials for more information. Any contributions you have will be automatically deducted from your first two paychecks each month on a pre-tax basis.

Pre-Tax Contributions

If the medical and dental coverages you choose require contributions, you have the advantage of paying them with pre-tax dollars. This means that your contributions are deducted from your paychecks before you pay Social Security taxes, federal income taxes, and most state and local income taxes. Deducting these payments lowers your taxable income, so your taxes are less. Thus, your take-home pay is higher than if you paid with after-tax dollars. If you're not already using this benefit, complete an enrollment form, available from your Departmental Payroll/Personnel Assistant.

medical

Your medical coverage should meet your needs as much as possible. That's why the City gives you five medical plans from which to choose. You can select the plan that best fits your health care situation and provides the financial protection you want. There are three types of medical plans offered:

- ***Point-of-Service (POS) Plans*** – Included are the POS 100 Plan, and the POS 90 Plan. A primary care physician, whom you choose at enrollment, oversees your medical care. He or she will refer you to specialists when necessary and arrange any hospitalization or surgery you need. Services rendered by a POS provider and approved by your PCP will be covered at the highest level – 100%, after deductible, for most services with the POS 100 Plan; or 90%, after deductible, for most services with the POS 90 Plan. For some services, copayments are required.

  You have the freedom to obtain care without approval from your PCP, or to see a non-POS provider, but services are then covered at 50% of usual and customary, higher deductible amounts apply, and claim forms are required.

- ***Preferred Provider Option (PPO) Plans*** – Included are the standard PPO and the High Deductible PPO Plan. The High Deductible Plan is offered at a lower cost and is designed for those who don't mind paying a higher deductible before the plan pays benefits. The PPO offers an extensive network that includes physicians, hospitals, and other types of health care providers. As long as you use providers who participate in the network, your care will be covered at the highest benefit level – generally 80%, after deductible, with the standard PPO Plan; and 90%, after deductible, with the High Deductible PPO Plan. For some services, copayments are required. A referral from your PCP is not required in order for you to see a specialist.

  You always have the option to be treated by non-network providers, but services are then covered at 60% of usual and customary, higher deductible amounts apply, and claim forms are required.

  If you enroll in the High Deductible Plan, you are encouraged to participate in the Health Care Flexible Spending Account to help reduce your out-of-pocket costs for covered services.

- ***HMO Plan*** – When you enroll in the PacifiCare HMO, you agree to use only PacifiCare doctors, facilities and medical groups for all of your medical care. You must choose a Participating Medical Group (PMG), and Primary Care Physician (PCP) to manage your care. PacifiCare covers most services at 100%, with no deductible, as long as you use providers who belong to your PMG. Office visit copayments are $10, and there are no claim forms.

  Any care you receive without approval from your PCP is not covered. Emergency room services require a $50 copay per visit. This copay is waived if you are admitted to the hospital.

INFORMATION AT YOUR FINGERTIPS

The City's intranet website is a great source for benefit plan and provider information. Visit us at http://wmirror.

(Click on "HR Employee Page.")

Your health plan website also offers up-to-date provider information, as well as useful tips on wellness, nutrition and disease prevention. Information is at your fingertips simply by visiting the world-wide-web:

For Great-West Healthcare, visit www.mygreatwest.com.

For PacifiCare, visit www.pacificare.com.

For a complete list of plan representatives, websites and telephone numbers, refer to your "If You Have Questions" card. Provider directories and plan booklets are an additional source of information, and are available through your Departmental Payroll/Personnel Assistant.

NEW — Prescription Drug Coverage

As was reported in last year's Benefits Summary, prescription drugs remain one of the leading causes of escalating health care costs. To help manage these rising costs, the City now offers a three-tier prescription drug program to employees enrolled in the POS 100 Plan, POS 90 Plan, or standard PPO Plan. The program is administered by Express Scripts.

When you present your identification card at a participating pharmacy, you will be charged a copayment, based on the type of prescription you receive. The plan's formulary includes the top 25 prescription drugs most commonly used by City employees and retirees, based on utilization reports.

Type of Rx	Your Copayment
Generic	$10 (30-day supply)
Brand Preferred	$25 (30-day supply)
Brand Non-preferred	The higher of $40 or 30% (30-day supply)
Mail Order	Two-times the applicable copay for 90-day supply

Key Terms

Formulary – the list of drugs that the plan covers. The City's plan features an "open" formulary, which means you may still receive benefits for prescription drugs that do not appear on the formulary, but your costs will be higher.

Generic – a drug that is identical in strength, concentration, and dosage form to a brand-name drug, and that generally is made available when patent protection expires on the brand-name drug. Generic drugs cost significantly less than their brand-name counterparts, which is why there is only a $10 copayment when you purchase these drugs through the plan.

Brand Preferred – those brand-name drugs that are named on the plan's formulary. The plan copayment for these drugs is $25 for a 30-day supply.

Brand Non-Preferred – those brand-name drugs that do not appear on the plan's formulary. The copayment for these drugs is the higher of $40 or 30% of the actual cost. This means that if the cost of your prescription is $100, you would have to pay the higher of $40, or 30% of 100. Since 30% of $100 is $30 (which is less than $40) your cost for the brand non-preferred drug would be $40.

Save With Mail Order

If you take maintenance medications for conditions such as high blood pressure, diabetes, or asthma, you can save money for yourself and the plan by purchasing your prescriptions through Express Scripts Mail Order. For two copayments you receive a 90-day supply, rather than a 30-day supply. You also gain the convenience of home delivery.

If You Enroll in the High Deductible PPO or PacifiCare

If you enroll in the High Deductible PPO Plan, you must first satisfy the plan's deductible before receiving prescription drug benefits. After you meet the deductible, the plan pays 90% of eligible expenses at network pharmacies, or 60% at non-network pharmacies.

If you enroll in PacifiCare, your copayments are $5 for generic, $15 for brand-name, and $25 for non-formulary prescriptions. Mail-order services are available for two-times the regular copay for a 90-day supply.

Mental Health Services

For Great-West Healthcare Plans

When you are enrolled in any Great-West Healthcare plan, your mental health benefits (including alcohol and chemical dependency) are provided by Associated Therapists, Inc. To receive services, call (714) 898-0362. You do not need a referral from your primary care physician to use these services. However, if you are out of Southern California and are a POS member, you should contact your PCP for a referral to a Mental Health Provider. If you are a PPO Member out of area, contact Great-West Healthcare Member Services at (800) 766-3206 or visit the Great-West website at www.mygreatwest.com.

For PacifiCare Plans

The PacifiCare Plan includes coverage for Severe Mental Illness (SMI) for adults and children, Serious Emotional Disturbances (SED) of a child, and Chemical Dependency (CD) coverage provided through PacifiCare Behavioral Health Incorporated (PBHI).

Members and eligible dependents always have direct, around-the-clock access to behavioral health benefits. You do not need to go through your primary care physician for a referral and all services are completely confidential. Call (800) 999-9585.

Refer to your Schedule of Benefits for a list of covered services, copayments, exclusions, and limitations.

About the Health Care Provider Groups

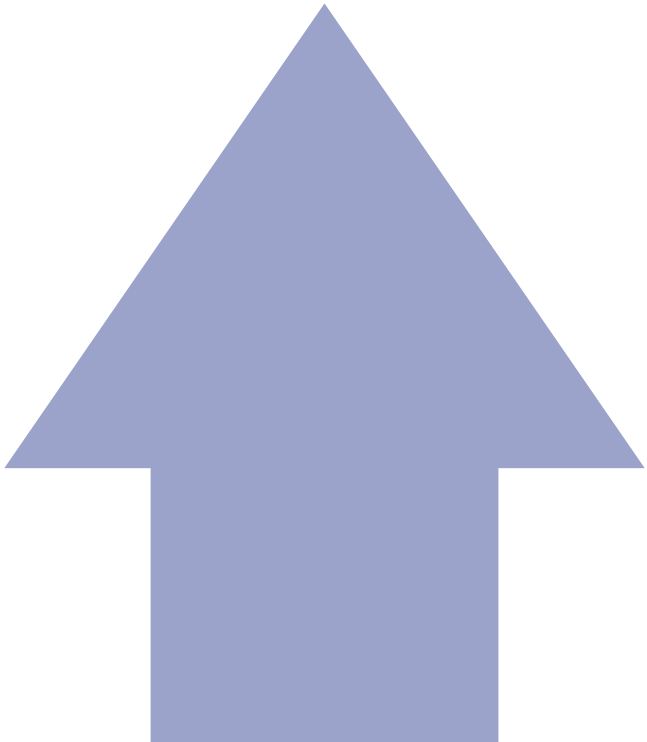
Here are some things to keep in mind as you weigh your medical plan options:

- Consider the location of the PCP (for the POS plans and PacifiCare HMO) or the PPO network providers you may use. Your physician should be within a reasonable distance (about 30 miles) of your home or office.
- You must select a PCP if you enroll in one of the POS plans or PacifiCare. You may choose different PCPs for yourself and each of your family members, if you wish.
- The network of chiropractors available to Great-West and PacifiCare members is called American Specialty Health Plans (ASHP). It features quality providers throughout California. You do not need a referral from your primary care physician to use these providers. For help locating an ASHP provider, call (800) 678-9133.
- The City's PPO plans have national networks of physicians and hospitals. Network providers are often available when you travel or if your dependents live in other areas.
- PacifiCare covers urgent and emergency services outside your service area when you travel, or for students who attend school full-time.

Help Control Health Care Costs

The City, employees, service providers and insurance groups must work together to help manage health care costs. Employees can start by becoming informed benefits consumers and by shopping for value when it comes to health care. Here are steps you can take to save money for yourself and the plan:

- Stay healthy. Experts say the first line of defense against rising health care costs is to take preventive measures. That means eat healthy, exercise, don't smoke, and get regular check-ups. If you need medicine, take it as prescribed by your doctor to avoid health complications and lengthy hospital stays.
- Use network providers for primary care and referrals. The Plan has negotiated special rates with network providers to help keep costs affordable without sacrificing quality. Take advantage of this savings opportunity.
- Always request generic drugs. Generic drugs can cost up to 95% less than their brand-name counterparts, yet they are equally effective.
- Comparison shop and consider reasonable options. The copayment for your prescription cough medicine, for example, may cost more than an over-the-counter product that may be equally effective. Do not spend more than you have to.
- Use Mail-Order pharmacy. The Mail-Order pharmacy allows you to buy larger quantities at less cost. The "volume discount" adds up to savings for you and the Plan.
- Take advantage of the Plan's well-baby and maternity care programs. These programs have been proven to reduce Plan costs by helping patients identify and avoid risks to a pregnancy.
- Save the emergency room for emergencies. Talk to your doctor about the best way to receive care during off-hours or on the weekend. As a reminder, the City provides a generous sick leave program that allows you to see your doctor during regular office hours (when services are less expensive).
- Request a detailed hospital bill and review it carefully. Studies show that 90% of all hospital bills have billing errors. By reviewing your bill, you can prevent yourself and the Plan from paying for services you did not receive.
- Use the Health Care Flexible Spending Account and increase your spending power for out-of-pocket health care expenses.
- Always get a second opinion for surgeries.
- Always follow precertification procedures for hospitalizations and surgeries. Precertification ensures that recommended treatment is appropriate and provided in the most cost-effective setting.
- Ask questions and read your printed materials. Talk to your doctor about reasonable treatment alternatives that may be more cost effective. Visit your plan's website for information on how to use your benefits efficiently.



Comparing Plan Benefits

This table summarizes benefits for each of the City's medical plans. Plan year deductibles are the amounts you pay each year (where applicable) before your plan begins paying benefits.

	POS 100 Plan	POS 90 Plan	PPO Plan	High Deductible PPO Plan	PacifiCare of California High Plan *PCP/PMG Approved Care Only***
Plan Year Deductible	***In-Network:*** $100 individual $200 family ***Out-of-Network:*** $300 individual $600 family	***In-Network:*** $100 individual $200 family ***Out-of-Network:*** $300 individual $600 family	***In-Network:*** $300 individual $600 family ***Out-of-Network:*** $500 individual $1,000 family	***In-Network:*** $1,000 individual $2,000 family ***Out-of-Network:*** $1,000 individual $2,000 family	$0
Annual Maximum	***In-Network:*** Unlimited ***Out-of-Network:*** $500,000	***In-Network:*** Unlimited ***Out-of-Network:*** $500,000	***In-Network:*** Unlimited ***Out-of-Network:*** $500,000	***In-Network:*** Unlimited ***Out-of-Network:*** $500,000	Unlimited
Covered Expense/Out-of-Pocket Limit	***In-Network:*** Not applicable ***Out-of-Network:*** No limit	***In-Network:*** Plan pays 100% after you reach $25,000 (i.e. $2,500 of out-of-pocket expenses excluding deductibles & copayments) for each covered person ***Out-of-Network:*** No limit	***In-Network:*** Plan pays 100% after you reach $30,000 (i.e. $6,000 of out-of-pocket expenses excluding deductibles and copayments) for each covered person ***Out-of-Network:*** No limit	***In-Network:*** Plan pays 100% after you reach $25,000 (i.e. $2,500 of out-of-pocket expenses excluding deductibles & copayments) for each covered person ***Out-of-Network:*** No limit	$1,000 annual copay maximum per individual (limit of three per family)
Hospitalization	***In-Network:*** 100%* ***Out-of-Network:*** 50%* up to covered daily maximum of $300 ($150 a day paid maximum)	***In-Network:*** 90%* ***Out-of-Network:*** 50%* up to covered daily maximum of $300 ($150 a day paid maximum)	***In-Network:*** You pay $200 per confinement, then covered at 80%* ***Out-of-Network:*** You pay $500 per confinement, then covered at 60%* up to covered daily maximum of $300 ($180 a day paid maximum)	***In-Network:*** 90%* ***Out-of-Network:*** 60%* up to covered daily maximum of $300 ($180 a day paid maximum)	Semi-private room or ICU with ancillary services covered in full for unlimited days (include SMI benefits mandated by AB88)
Hospital Preadmission Tests	***In-Network:*** 100%* ***Out-of-Network:*** 50%*	***In-Network:*** 90%* ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 60%*	100%**
Inpatient & Outpatient Surgery	***In-Network:*** 100%* ***Out-of-Network:*** 50%*	***In-Network:*** 90%* ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 60%*	100%**
Physician Charges for Hospital Care & Surgery	***In-Network:*** 100%* ***Out-of-Network:*** 50%*	***In-Network:*** 90%* ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 60%*	100%**
Emergency Room	***In-Network:*** 100% after you pay $75. Payment waived if hospitalized. If possible, contact PCP for instructions; otherwise, seek treatment at nearest facility, then contact your PCP within 48 hours. ***Out-of-Network:*** 50%*	***In-Network:*** 100% after you pay $75. Payment waived if hospitalized. If possible, contact PCP for instructions; otherwise, seek treatment at nearest facility, then contact your PCP within 48 hours. ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 60%*	$50 copayment per visit. Waived if admitted to the hospital

* Paid after the deductible **Non-approved care is not covered. Care must be approved by PCP or PMG (Participating Medical Group). ***PCP is your Primary Care Physician

	POS 100 Plan	POS 90 Plan	PPO Plan	High Deductible PPO Plan	PacifiCare of California High Plan *PCP/PMG Approved Care Only***
Physician Office Visits	***In-Network:*** You pay $20 copay, then covered at 100% ***Out-of-Network:*** 50%*	***In-Network:*** You pay $20 copay, then covered at 100% ***Out-of-Network:*** 50%*	***In-Network:*** You pay $25 copay, then covered at 100% ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 60%*	$10 copay per visit
Outpatient X-ray & Laboratory	***In-Network:*** 100%* ***Out-of-Network:*** 50%*	***In-Network:*** 90%* ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 60%*	Covered in full
Maternity Care	***In-Network:*** 100%* ***Out-of-Network:*** 50%*	***In-Network:*** 90%* ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 60%*	Covered in full except for certain elective procedures, which are subject to copays
Birthing Centers	***In-Network:*** 100% (24-hour stay starting at child's birth) ***Out-of-Network:*** Same as In-Network	***In-Network:*** 100% (24-hour stay starting at child's birth) ***Out-of-Network:*** Same as In-Network	***In-Network:*** 100% (24-hour stay starting at child's birth) ***Out-of-Network:*** Same as In-Network	***In-Network:*** 100% (24-hour stay starting at child's birth) ***Out-of-Network:*** Same as In-Network	100%**
Adult Physical & Routine Well-Baby Care	***In-Network:*** You pay $20 at the time of visit, then covered at 100%. Women can self refer for annual OB/GYN visit within physician group ***Out-of-Network:*** 50%* up to $250 per year	***In-Network:*** You pay $20 at the time of visit, then covered at 100%. Women can self refer for annual OB/GYN visit within physician group ***Out-of-Network:*** 50%* up to $250 per year	***In-Network:*** You pay $25 at the time of visit, then covered at 100% ***Out-of-Network:*** 60%* up to $250 per year	***In-Network:*** Some services covered at 100% with no deductible up to $200 per year ***Out-of-Network:*** 60%* up to $200 per year	Covered in full after $10 copayment. (Waived for Well-Baby Care for children under 2) Limited to one exam each calendar year
Prescription Drugs	***In-Network:*** When you use an Express Scripts pharmacy: $10 generic; $25 brand preferred; $40 or 30% for brand non-preferred. Mail Order available ***Out-of-Network:*** When you use non-Express Scripts pharmacy, you must file a claim form with Express Scripts; the benefit amount paid will be reduced	***In-Network:*** When you use an Express Scripts pharmacy: $10 generic; $25 brand preferred; $40 or 30% for brand non-preferred. Mail Order available ***Out-of-Network:*** When you use non-Express Scripts pharmacy, you must file a claim form with Express Scripts; the benefit amount paid will be reduced	***In-Network:*** When you use an Express Scripts pharmacy: $10 generic; $25 brand preferred; $40 or 30% for brand non-preferred. Mail Order available ***Out-of-Network:*** When you use non-Express Scripts pharmacy, you must file a claim form with Express Scripts; the benefit amount paid will be reduced	Covered under medical plan; subject to deductible & coinsurance ***In-Network:*** Plan pays 90%* ***Out-of-Network:*** Plan pays 60%*	You pay $5 per generic, $15 per brand; $25 per non-formulary Mail order services available at 2 times the regular copay for 90-day supply
Home Health	***In-Network:*** Plan pays 100% of reasonable & customary charges for visits to home and services and supplies provided in home Plan pays for only one visit per day up to 90 visits per year (4 hours = 1 visit) ***Out-of-Network:*** 50%*	***In-Network:*** Plan pays 100% of reasonable & customary charges for visits to home and services and supplies provided in home Plan pays for only one visit per day up to 90 visits per year (4 hours = 1 visit) ***Out-of-Network:*** 50%*	***In-Network:*** Plan pays 100% of reasonable & customary charges for visits to home and services and supplies provided in home Plan pays for only one visit per day up to 90 visits per year (4 hours = 1 visit) ***Out-of-Network:*** 60%*	***In-Network:*** Plan pays 100% of reasonable & customary charges for visits to home and services and supplies provided in home Plan pays for only one visit per day up to 90 visits per year (4 hours = 1 visit) ***Out-of-Network:*** 60%*	Covered in full

* Paid after the deductible **Non-approved care is not covered. Care must be approved by PCP or PMG (Participating Medical Group). ***PCP is your Primary Care Physician

	POS 100 Plan	POS 90 Plan	PPO Plan	High Deductible PPO Plan	PacifiCare of California High Plan *PCP/PMG Approved Care Only***
Chiropractic Care	***In-Network:*** Self-referral benefit, no PCP approval required. If you use ASHP network chiropractors, plan pays 100%* of contracted charges (up to $30 paid per visit) up to $1,000 a year. ***Out-of-Network:*** Self-referral benefit, no PCP approval required. If you use non-network chiropractor, plan pays 50%* of covered charges up to a $60 per visit maximum ($30 paid per visit) up to $1,000 a year	***In-Network:*** Self-referral benefit, no PCP approval required. If you use ASHP network chiropractors, plan pays 90%* of contracted charges (up to $30 paid per visit) up to $1,000 a year. ***Out-of-Network:*** Self-referral benefit, no PCP approval required. If you use non-network chiropractor, plan pays 50%* of covered charges up to a $60 per visit maximum ($30 paid per visit) up to $1,000 a year	***In-Network:*** When you use the ASHP chiropractic network, plan pays 80%* of network contracted charges (up to $30 paid per visit) up to $1,000 a year. ***Out-of-Network:*** Plan pays 50%* of covered charges up to a $60 per visit maximum ($30 paid per visit) up to $1,000 a year.	***In-Network:*** When you use the ASHP chiropractic network, plan pays 90%* of network contracted charges (up to $30 paid per visit) up to $1,000 a year. ***Out-of-Network:*** Plan pays 50%* of covered charges up to a $60 per visit maximum ($30 paid per visit) up to $1,000 a year.	$10 copayment; 40 visits (combined with acupuncture) per year through ASHP provider
Acupuncture	***In-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum ***Out-of-Network:*** Same as In-Network	***In-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum ***Out-of-Network:*** Same as In-Network	***In-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum ***Out-of-Network:*** Same as In-Network	***In-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum ***Out-of-Network:*** Same as In-Network	$10 copayment; 40 visits (combined with chiropractic) per year through ASHP provider
Durable Medical Equipment (DME)	***In-Network:*** With approval from your PCP, the plan pays 100%* when you rent or purchase DME from a contracted facility ***Out-of-Network:*** 50%*	***In-Network:*** 90%* ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 60%*	100%**
Hearing Aids	***In-Network:*** 100%* up to $1,000 every 3 years ***Out-of-Network:*** 50%* up to $1,000 every 3 years	***In-Network:*** 90%* up to $1,000 every 3 years ***Out-of-Network:*** 50%* up to $1,000 every 3 years	***In-Network:*** 80%* up to $1,000 every 3 years ***Out-of-Network:*** 60%* up to $1,000 every 3 years	***In-Network:*** 90%* up to $1,000 every 3 years ***Out-of-Network:*** 60%* up to $1,000 every 3 years	100%; limit of one for each ear in a 3-year period** (hearing exam covered in full after $10 copay)
Orthotics	***In-Network:*** 100%* up to $75 every 3 years ***Out-of-Network:*** 50%* up to $75 every 3 years	***In-Network:*** 90%* up to $75 every 3 years ***Out-of-Network:*** 50%* up to $75 every 3 years	***In-Network:*** 80%* up to $75 every 3 years ***Out-of-Network:*** 60%* up to $75 every 3 years	***In-Network:*** 90%* up to $75 every 3 years ***Out-of-Network:*** 60%* up to $75 every 3 years	Not covered

* Paid after the deductible **Non-approved care is not covered. Care must be approved by PCP or PMG (Participating Medical Group). ***PCP is your Primary Care Physician

	POS 100 Plan	POS 90 Plan	PPO Plan	High Deductible PPO Plan	PacifiCare of California High Plan *PCP/PMG Approved Care Only***
Inpatient Mental Health & Substance Abuse Treatment	***In-Network:*** 100%*; 30-day plan year benefit; 60 days lifetime ***Out-of-Network:*** 50%* covered up to a $300 per day maximum ($150 per day paid benefit); 30-day plan year benefit; 60 days lifetime	***In-Network:*** 90%*; 30-day plan year benefit; 60 days lifetime ***Out-of-Network:*** 50%* covered up to a $300 per day maximum ($150 per day paid benefit); 30-day plan year benefit; 60 days lifetime	***In-Network:*** You pay $200 per confinement. Then covered at 80%* up to $15,000 per plan year for all inpatient care ***Out-of-Network:*** You pay $500 per confinement. Then covered at 60%* up to $300 per day ($180 paid maximum per day) $15,000 per plan year maximum for all inpatient care	***In-Network:*** 90%* up to $15,000 per plan year for all inpatient care ***Out-of-Network:*** 60%* up to $300 per day ($180 paid maximum per day) $15,000 per plan year maximum for all inpatient care	Covered in full for unlimited days; members must access PacifiCare Behavioral Health Network. (Substance abuse subject to $25,000 annual and $35,000 lifetime maximum for inpatient & outpatient care combined)
Outpatient Mental Health & Substance Abuse Benefits	***In-Network:*** You pay $20 per visit, then covered at 100%, 20 visits per plan year maximum benefit for all outpatient care **Self-Referral Restriction:** You can only self refer to an Associated Therapists provider ***Out-of-Network:*** 50%* of up to $75 of covered charges per visit; 20 visits per plan year maximum benefit for all outpatient care	***In-Network:*** You pay $20 per visit, then covered at 100%, 20 visits per plan year maximum benefit for all outpatient care **Self-Referral Restriction:** You can only self refer to an Associated Therapists provider ***Out-of-Network:*** 50%* of up to $75 of covered charges per visit; 20 visits per plan year maximum benefit for all outpatient care	***In-Network:*** You pay $25 per visit. Then psychologists are covered at 100%; psychiatrists are covered up to $75 per visit. $1,500 plan year maximum for all outpatient care ***Out-of-Network:*** 60%* covered up to $75 per visit. $1,500 plan year maximum for all outpatient care	***In-Network:*** Psychologists are covered at 90%*; psychiatrists covered at 90%* to $75 per visit. $1,500 plan year maximum for all outpatient care ***Out-of-Network:*** 60%* covered up to $75 per visit $1,500 plan year maximum for all outpatient care	Covered in full after $10 copayment per visit for mental health; unlimited visits. Covered at 100% for substance abuse; subject to $25,000 annual and $35,000 lifetime maximum for inpatient & outpatient care combined. Members must access PacifiCare Behavioral Health Network
Lifetime Maximum Benefit for Mental Health Treatment	***In-Network:*** 60-day maximum for all inpatient ***Out-of-Network:*** Same as In-Network	***In-Network:*** 60-day maximum for all inpatient ***Out-of-Network:*** Same as In-Network	***In-Network:*** $50,000 for all inpatient & outpatient ***Out-of-Network:*** Same as In-Network	***In-Network:*** $50,000 for all inpatient & outpatient ***Out-of-Network:*** Same as In-Network	Unlimited, except as noted above for substance abuse
Skilled Nursing Facilities (SNF)	***In-Network:*** 100%* Limit 90 days per plan year ***Out-of-Network:*** 50%* Limit 90 days per plan year	***In-Network:*** 90%* Limit 90 days per plan year ***Out-of-Network:*** 50%* Limit 90 days per plan year	***In-Network:*** 80%* Limit 90 days per plan year ***Out-of-Network:*** 60%* up to $90 per day Limit 90 days per plan year	***In-Network:*** 90%* Limit 90 days per plan year ***Out-of-Network:*** 60%* up to $90 per day Limit 90 days per plan year	Covered in full up to 100 consecutive days from first treatment per disability
Hospice Care	***In-Network:*** 100% ***Out-of-Network:*** 50%* (some limits apply)	***In-Network:*** 100% ***Out-of-Network:*** 50%* (some limits apply)	***In-Network:*** 100% ***Out-of-Network:*** 60%* (some limits apply)	***In-Network:*** 100% ***Out-of-Network:*** 60%* (some limits apply)	Covered in full up to 180 days per lifetime

* Paid after the deductible **Non-approved care is not covered. Care must be approved by PCP or PMG (Participating Medical Group). ***PCP is your Primary Care Physician

Vision Care for POS and PPO Plans

Vision care for the City's POS and PPO plans is provided through a network of eye care professionals called Medical Eye Services (MES). Eye exams are covered in full when you use an MES optometrist or ophthalmologist. If you participate in the PacifiCare HMO, eye exams, standard frames and lenses are covered in full once every 12 months if you use an MES eye care professional. However, to receive 100% coverage for eyeglasses, you must get your glasses from an MES provider.

	Participating MES Provider Plan Pays…	Non-Participating Provider Plan Pays…
Exams	100%	$57.50 for optometrist $67.50 for ophthalmologist
Single vision lenses	100%*	$45
Bifocal lenses	100%*	$63
Trifocal lenses	100%*	$80
Frames	Up to $60	Up to $40
Contact lenses (cosmetic)	$100	$100
* Must be medically necessary; anything for cosmetic purposes is extra.		

comparing plan rules

Question: What if I need emergency care or care away from home?

POS Plans
If possible, contact your PCP for instructions. Otherwise, seek treatment at the nearest facility, then contact your PCP within 48 hours. Your PCP must authorize this treatment in order for you to receive highest plan benefits.

PPO & High Deductible PPO
If possible, call Great-West at 1-800-766-3206 and ask if there is a PPO facility in the area. Otherwise, seek treatment at the nearest facility. Any care received out-of-network will be covered at 60% after deductible.

HMO Plan
Call 911 or seek treatment at the nearest emergency facility. Contact your PCP within 48 hours, or when reasonably possible.

Question: Is pre-treatment authorization necessary before hospitalization or surgery?

POS Plans
Your PCP must authorize your treatment, refer you to a POS provider, and call for precertification if you are hospitalized or have outpatient surgery and are in-network.

PPO & High Deductible PPO
No authorization is necessary when you use PPO providers. However, if you're hospitalized or have surgery out-of-network, call 1-800-766-3206 for preauthorization before your treatment, if possible, or within 48 hours following treatment.

HMO Plan
It is necessary that your PCP authorize your treatment, unless an emergency condition exists as described above.

Preexisting Conditions

A preexisting condition is an illness, injury, or pregnancy for which you or your dependent received medical treatment within 90 days before your City medical coverage began. Your preexisting condition will not be covered until you participate in a City medical plan for six continuous months. These rules apply for:

- Newly hired employees (or rehired employees who didn't have COBRA) electing one of the POS plans or PPO plans
- Employees enrolling during open enrollment who have participated in the HMO Plan for less than six months and want to switch to one of the POS plans or PPO plans.

However, if you can provide a certificate proving you had health care coverage from another employer or carrier for six consecutive months before your City medical coverage began, your preexisting condition *will* be covered. (Or your preexisting period will be reduced one day for each day of continuous coverage (with no significant break of 63 or more days) just prior to your effective date of coverage under the PPO or POS plans.)

Preexisting condition rules do *not* apply for:

- Most employees enrolling during open enrollment (see the one exception above)
- Employees who choose the PacifiCare HMO Plan.

YOU MAY WAIVE YOUR MEDICAL COVERAGE

You have the option to waive medical coverage. To do so, you must complete a waiver form, available from your Departmental Payroll/Personnel Assistant.

Note that if you decline medical coverage, you:

• May not participate in dental coverage or life insurance, and

• Must wait until the next open enrollment period to enroll for future medical coverage.

dental

If you enroll in any one of the City's medical plans, you automatically receive dental coverage. You have a choice of two dental plans:

- ***Delta Dental Plan*** — This plan allows you to use any dentist of your choice. Your out-of-pocket costs are determined by the dentist you use — a Delta Preferred Option (DPO) dentist, Delta dentist, or an out-of-network dentist. It's to your advantage to select a Delta dentist or a dentist who participates in the DeltaPreferred Option (DPO) network. For care from DPO providers, you pay no deductible, and the plan pays a plan year maximum of $2,000.

  When you use a Delta dentist or an out-of-network dentist, you first pay a deductible. Then the plan pays a percentage of your costs up to $1,000 each plan year in covered benefits. However, by using one of the many Delta dentists throughout California, you will receive the advantage of a lower fee schedule than you would receive from an out-of-network dentist.

  With the Delta Dental Plan, you have the option to go to a specialist of your choice without preapproval, and you may change your dentist at any time without preapproval. Claim forms are required only if you receive care from out-of-network dentists.

- ***PacifiCare Dental Plan*** — When you enroll, you choose a dentist who belongs to the PacifiCare network of dental care providers. PacifiCare dentists are located in most areas of California. When you use the dentist you select at the time you enroll, most treatments are covered at 100%. However, if you use any other dentist, you receive no benefits. Each dependent may choose a different dentist, and claim forms are not required.

Comparing Plan Benefits

This table summarizes benefits under the dental plans. Refer to your employee handbook for coverage details.

PLAN BENEFITS	DELTA DENTAL PLAN		PACIFICARE DENTAL PLAN
	DPO Network	*Other Delta Dentists*	
Your Plan Year Deductible	$0	$50 individual $150 family	$0
Maximum Plan Year Benefit	$2,000 per person	$1,000 per person	$0
Preventive Treatment (oral examinations, teeth cleanings, x-rays)	100%*	100%** (deductible doesn't apply)	100%
Routine Treatment (fillings, extractions, treatment of gum disease)	80%*	80%**	100%
Major Treatment (crowns, bridges, dentures)	80%*	80%**	100%
Emergency Treatment (emergency exam and palliative treatment of dental pain)	100%*	100%**	Contact your assigned dental office. If your condition prevents you from doing so, you must receive care from a licensed dentist. Your reimbursement will be subject to applicable copayments.
Dental Accident	100%*	100%** (deductible doesn't apply)	100%
Orthodontia	50%*; $2,000 lifetime maximum for child; $1,000 lifetime maximum for adult	50%** (deductible doesn't apply); $2,000 lifetime maximum for child; $1,000 lifetime maximum for adult	You pay up to $250 in start-up fees. You may be charged up to $500 for full bands or $250 for partial bands. A PCD orthodontist must provide treatment.
Preexisting Conditions	None	None	No coverage for dental procedures started before your participation in this plan.

** Based on DPO allowed fees. ** Based on Delta Dental allowed fees.*

YOU & YOUR DEPENDENTS MAY USE DIFFERENT DENTISTS

Under both dental plans, you and your dependents may use different dentists. When enrolling in PacifiCare Dental, simply choose the network dentist you want for each family member.

NEED MORE INFORMATION?

To learn more about the dental plans:

- **Attend a Q&A session during open enrollment;**
- **Check Delta Dental's web page, or find Delta's information through the City's intranet address; or**
- **Ask your Departmental Payroll/Personnel Assistant for dental plan details.**

long term care insurance

The City of Long Beach is pleased to offer Long Term Care Insurance.

This plan provides financial help if you require care in a nursing facility, or at home, as a result of a loss of functional capacity or cognitive impairment due to injury, sickness, or advanced age.

Qualifying for benefits is based upon a need for assistance with any two of six activities of daily living including eating, bathing, dressing, toileting, continence, or transferring, and/or cognitive impairment such as dementia or Alzheimer's disease.

The basic plan provides $1000 of monthly benefits for up to three years in a facility.

Plan "Buy up Options" allow you to increase monthly benefits in units of $1000 up to $6000 monthly, and to add professional home care and inflation protection.

The plan is portable and can be taken with you if your employment discontinues or upon retirement.

The plan is also available to spouses, parents, grandparents, in-laws, part-time permanent employees, and retirees.

The younger you are, the lower the premium.

Premiums are based on age at time of enrollment and the level of benefits selected.

Employees who did not enroll in Long Term Care during the initial enrollment period, or within 30-days of their original hire date, may enroll during this Open Enrollment period. However, the employee must complete a medical questionnaire to determine eligibility.

For more information, please see your Departmental Payroll/Personnel Assistant.

EXAMPLES OF MONTHLY RATES

	PLAN 1	**PLAN 2** BASE PLAN WITH PROFESSIONAL HOME CARE	**PLAN 3** BASE PLAN WITH COMPOUND INFLATION	**PLAN 4** BASE PLAN WITH PROFESSIONAL HOME CARE COMPOUND INFLATION
AGE	BASE PLAN	OPTION	OPTION	OPTIONS
18-30	1.80	3.00	6.60	9.40
35	2.10	3.40	7.60	10.70
40	2.60	4.10	8.90	12.30
45	3.40	5.20	10.60	14.60
50	4.50	6.60	12.70	16.70
55	6.40	8.70	15.90	19.80
60	9.60	11.90	20.50	24.10
65	16.30	18.70	30.70	34.10
70	27.90	30.80	46.10	50.00

life insurance

Life insurance helps protect your family from a sudden loss of income in the event of your death. If you enroll in a City medical plan, you automatically receive $20,000 of life insurance for yourself.

You must complete a form designating your beneficiaries who will receive your life insurance should you die. You may change your beneficiaries at any time.

IF YOU ARE TERMINALLY ILL

If you're terminally ill, you may receive part of your life insurance while living. For more information, contact Human Resources.

City of Long Beach In-Hospital Indemnity Plan

The City of Long Beach offers the In-Hospital Indemnity Plan, which pays benefits if you're hospitalized. Here's how it works:

- You receive $100 for each day you are in the hospital or $200 for each day you are in intensive care.
- This benefit is paid in addition to any other medical coverage you have.
- You may enroll yourself only or your dependents, too. New dependents, including newborns, must be enrolled within 30 days of eligibility. (See Eligibility on page 3).
- Claim forms are necessary for payment and must be submitted within 15 months of the date the claim was incurred.

Costs for Coverage

Your costs for the In-Hospital Indemnity Plan are based on your age and who you enroll, as shown in this table. Contributions are deducted from your paycheck once a month after taxes are withheld.

	MONTHLY COSTS			
YOUR AGE	**EMPLOYEE ONLY**	**EMPLOYEE & SPOUSE**	**EMPLOYEE & CHILDREN**	**ENTIRE FAMILY**
Birth-34	$3.62	$ 6.90	$ 7.29	$10.58
35-44	4.38	8.39	8.06	12.07
45-54	5.92	11.30	9.59	14.97
55-59	7.45	14.25	11.12	17.92
60-64	7.68	14.63	10.42	17.37
65-69 (half benefit only)	4.38	8.39	6.58	10.59

Note: If you have been participating in this plan since March 1994 or earlier, you're not required to pay contributions for coverage this year.

employee assistance program

Life is not always easy. Problems arise that can affect us physically, emotionally, or spiritually. Sometimes it helps to talk things out.

The Employee Assistance Program (EAP) offers professional, confidential assistance with personal problems. The program is provided through the City's Department of Health and Human Services, and it is available to all City employees and their immediate family members. The EAP has trained counselors who can assist you with:

- Marriage or family relationships
- Work-related problems
- Financial or legal difficulties
- Stress, anxiety, or depression
- Alcohol or drug dependency
- Locating community resources, such as child daycare.

If your counselor thinks you should have further professional help, he or she will refer you to the services you need.

Be assured that your counseling is completely confidential. Your supervisor will not be aware of your participation unless you request it, and nothing about the EAP will be placed in your personnel file.

CALL AN EAP COUNSELOR

To speak with an EAP counselor, call 570-4100 Monday-Friday. EAP services are provided at no cost to you.

continuing **health care coverage**

Under a law called the Consolidated Omnibus Budget Reconciliation Act (COBRA), you have the right to continue your medical and dental plan participation beyond when your City coverage would normally end. To do so, you must pay the full cost of medical and dental coverage, plus 2%.

COBRA INFORMATION

Refer to your employee handbook or contact your Departmental Payroll/Personnel Assistant for more information about COBRA coverage, including when coverage ends.

The duration of continued coverage through COBRA depends on your situation (called a qualifying event), as follows:

- If your employment is terminated (for reasons other than gross misconduct) or your hours are reduced so that you are no longer eligible, you may continue health coverage for yourself and dependents for up to 18 months.
- If your dependent loses coverage because of divorce, legal separation, your death, or if your child reaches the maximum eligible age, that dependent may continue health coverage for up to 36 months.
- If you or your dependent becomes disabled (as defined by Social Security) before or within 60 days after starting COBRA coverage, the disabled person may have up to 29 months of COBRA coverage from the date he or she was first eligible. You must pay an additional amount for this extended coverage.

To obtain COBRA coverage, you must make a written request to your Departmental Payroll/Personnel Assistant within 60 days of:

- The end of the month in which your qualifying event occurs or
- Receiving notice from your supervisor of a qualifying event.

You will be asked to complete an enrollment form. Payments for COBRA coverage must be mailed to the City by the 20th of each month for the following month's coverage.

Certificate of Health Care Coverage (HIPAA Certificate)

Your Departmental Payroll/Personnel Assistant will provide a certificate of health care coverage to you and/or your covered family members if health care coverage ceases under the City's health care program. The certificate provides future employers and insurance providers with verification that you (and/or your covered dependents) had coverage under a City of Long Beach-sponsored plan.

Preexisting conditions of a new plan will then be reduced by one day for each day that you and/or your dependents had continuous health care coverage. Continuous health care coverage, including COBRA, means having no significant break (normally 63 or more days), immediately prior to the effective date of coverage under the new plan.

flexible spending accounts

The Flexible Spending Accounts (FSA) are an effective way to increase your purchasing power for health and dependent care expenses, especially if you enroll in the High Deductible PPO Plan. Available to all permanent full-time employees, these accounts let you use pretax dollars to pay eligible health and dependent care expenses you traditionally would pay out-of-pocket with after-tax dollars. The tax savings can really add up!

To participate, you must complete an enrollment form. A new election is required each year.

How These Accounts Work

How much do you spend each year for out-of-pocket health care and dependent care expenses? Your answer will help you decide how much, if any, of your pretax pay to set aside in each account.

You can contribute up to $3,600 annually to the Health Care Account, and/or up to $5,000 annually to the Dependent Care Account. Your contributions are deducted from your pretax pay in equal amounts throughout the plan year. Once you elect to participate, you cannot change or stop your contributions during the plan year unless you have a qualified status change.

Your contributions are deducted from your paycheck before taxes are withheld. This means you do not pay Social Security tax, federal income tax and, in most cases, state and local income tax on the amounts you set aside for eligible expenses.

Paying Expenses

When you have an eligible expense, you pay the expense and then submit a Reimbursement Request Form along with your receipts. Checks from the plan are issued weekly and mailed to your home.

Eligible Expenses

Eligible health care expenses are those not covered by other insurance plans, such as deductibles, copayments, coinsurance, prescription drugs, hearing care and vision expenses.

Eligible dependent care expenses are those that enable you (or you and your spouse, if you are married) to work or attend school full-time. They include daycare, preschool programs, and after school care for children under age 13. Eligible expenses also include elder care, or care for dependents of any age who are not capable of caring for themselves.

For more information on eligible expenses call the plan administrator, Great-West Healthcare, at (800) 759-4952.

IMPORTANT!

Because of the special tax advantages, the IRS has a strict "Use It or Lose It" Rule that applies to these accounts. **Any funds you contribute but do not use during the plan year for eligible expenses must be forfeited.** You must estimate your expenses carefully.

Account Balance Inquiries

For updates on your FSA balance, or to learn the date and amount of the last check issued, call Great-West Healthcare at (800) 759-4952. Simply enter your Social Security Number and follow the voice prompts.

open enrollment
Q&A session Schedule

Health and Dental Insurance Representatives

Representatives from each Health and Dental carrier will be available at these locations to provide information about their plans and answer questions.

1ST WEEK

MONDAY - SEPTEMBER 27

Police Headquarters
Community Room
100 Long Beach Blvd.
7:00 – 9:00 a.m.

Parks, Rec. & Marine
Administration Building
Large Conf. Room
2760 Studebaker Rd.
10:30 a.m. – 12:00 p.m.

Public Service
Assembly Room
1601 San Francisco
2:00 – 3:30 p.m.

TUESDAY - SEPTEMBER 28

Health & Human Services
Room 204
2525 Grand Avenue
9:00 – 11:00 a.m.

Civic Center
Main Library , LL Lobby
101 Pacific Ave.
1:30 – 3:00 p.m.

WEDNESDAY - SEPTEMBER 29

Water Dept.
Assembly Room
1800 E. Wardlow
8:00 – 9:00 a.m.

Harbor
Maintenance Yard
1400 West Broadway
10:00 – 11:30 a.m.

Police West Station
Squad Room
1835 Santa Fe Ave.
1:30 – 3:30 p.m.

THURSDAY - SEPTEMBER 30

Long Beach Energy
Auditorium
2400 E. Spring St.
7:30 – 9:30 a.m.

Police Headquarters
Community Room
100 Long Beach Blvd.
11:30 a.m. – 1:00 p.m.

Harbor
Cafeteria
925 Harbor Plaza
2:00 p.m. – 3:30 p.m.

FRIDAY - OCTOBER 1

Police East Station
Squad Room
4800 Los Coyotes Diag.
7:00 – 9:00 a.m.

Civic Center
Main Library , LL Lobby
101 Pacific Ave.
10:00 – 11:30 a.m.

2ND WEEK

MONDAY - OCTOBER 4

Civic Center
Main Library LL Lobby
101 Pacific Ave.
11:30 a.m. – 1:30 p.m.

Water Dept.
Assembly Room
1800 E. Wardlow
3:00 – 4:00 p.m.

TUESDAY - OCTOBER 5

Public Service
Assembly Room
1601 San Francisco Ave.
9:00 – 10:30 a.m.

Environmental Services
Assembly Room
2929 E. Willow St.
11:30 a.m. – 1:00 p.m.

WEDNESDAY - OCTOBER 6

Long Beach Energy
Auditorium
2400 E. Spring St.
9:00 – 10:30 a.m.

Harbor
Maintenance Yard
1400 West Broadway
11:30 a.m. – 1:00 p.m.

THURSDAY - OCTOBER 7

Public Service
Assembly Room
1601 San Francisco Ave.
10:00 a.m. – 12:00 p.m.

Health & HumanServices
Room 204
2525 Grand Ave.
2:00 – 3:30 p.m.

FRIDAY - OCTOBER 8

Retiree Meeting
Main Library
Lower Level
10:00 a.m – 12:00 p.m.

PAYROLL/PERSONNEL ASSISTANT **PHONE LISTING**

DEPARTMENT	PAYROLL/PERSONNEL ASSISTANT	EXT	BACKUP	EXT
City Auditor	Debra Williams	86267	Cheryl Thorpe	86942
City Clerk	Irma Heinrichs	86228	Monique DeLaGarza	86981
City Manager	Phalla Chau	85198		
City Prosecutor	Sherri Seldon	85621	Michelle O'Neill	85617
Civil Service	Suanne Swan	86058	Beatriz Lacerda	86625
Community Development	Georgette Wittman	85799	Marian Kjenstad	86839
Financial Management	Gloria Harper	87006		
Fire	Melissa Swift	82514	Lori Hubbard-Jackson	82527
Harbor	Kathy Esquerra	590-4134/2238	Lois Wangsness	2235
Health & Human Services	Flor Pingol	84009	Angie Tran	84018
Animal Control	Patty (O'Keefe) Palmeri	83072		
Human Resources	Cathy Chace	86303	Debbie Maldonado	86302
Law	Tyler Pike	82200	Jacki Pittman	82209
Legislative	Erma Varnado	86801	Roxana Valencia	86605
Library	Pat Fierros	86945		
Long Beach Energy	Jeannine Franklin	82061	Stephanie Cadwell	82016
Oil Properties	Betty Garibay	83931	Sandra Flores	3902
Parks, Rec & Marine	Debbie Soto	83187	Letty Flores	83186
Planning & Building	Kathy Bangma	86333	Elvira Dice	86399
Police	Maria Macias	87458	Marie (Eva) Parham	87407
Public Works	Elisa Calderon	84692	Anne Herrera	84677
Technology Services ~				
Ntwrk/Dsktp/Compg Svcs	Jeanne Dome	86982		
Customer Svcs	Dina Lopez	86883		
Water	Wanda Mariner	82375		

Notice to Participants

New Federal laws impose certain requirements on group health plans. Under these new Federal laws, collectively referred to as HIPAA, a group health plan is limited in imposing pre-existing conditions; must offer employees and dependents the opportunity to enroll in the plan outside of open enrollment periods in certain situations; cannot discriminate on the basis of health status with respect to eligibility for plan participation and premium costs; cannot impose discriminatory lifetime or annual benefit limitations for participants with mental illness; and must permit hospital admissions (if otherwise covered by the plan) of at least 24 hours in the case of normal deliveries and 48 hours in the case of Cesarean Sections.

With respect to many of the above restrictions, the City of Long Beach is currently in compliance with State law requirements and many of the HIPAA requirements under Federal law. Further, the City of Long Beach does not discriminate on the basis of health status with respect to eligibility for health plan participation or premium costs.

As part of the new Federal law, plan sponsors of non-Federal government plans can elect to be exempt from the above-mentioned requirements. The City of Long Beach has elected exemption from HIPAA requirements for the plan year beginning December 1, 2004 and ending the following November 30, 2005.

Special Assistance

This Employee Benefit Summary information is available in an alternate format by request to the Department of Human Resources and Affirmative Action. If you need any special assistance or special materials to clearly and fully understand all of your benefit options, please call (562)570-6621. We would be more than happy to assist you in any way we can.